

Student Name: \_\_\_\_\_ Student ID Number. \_\_\_\_\_

**FORM A: Medical Provider Information: Asthma & Allergies** (This form is to be completed by a health professional only if the student requires special housing accommodations) Please complete the following information to assist Lebanon Valley College in determining your patient's need for air-conditioned housing. The information you provide will become a part of your patient's medical record at Lebanon Valley College. Thank you for your assistance.

**Consent for Release of Information:** I, \_\_\_\_\_, give  
Student Name  
\_\_\_\_\_ permission to provide the information requested below to the  
Medical Provider  
Student Services staff and the Coordinator of Disability Services. I also understand that this information will become a part of my permanent medical record at the Shroyer Health Center.

\_\_\_\_\_  
Student Signature Date

**ASTHMA**

1. **Current Diagnosis (select one)**
  - Exercise Induced Asthma
  - Intermittent Asthma
  - Persistent Asthma
  - Other (please define) \_\_\_\_\_
2. **Current Asthma Medications (please note medication name and dosage)**
  - Short-Acting Beta Agonists \_\_\_\_\_
  - Long-Acting Beta Agonists \_\_\_\_\_
  - Inhaled Corticosteroids \_\_\_\_\_
  - Other \_\_\_\_\_
3. **Please check any of the following which are true for your patient (dates required)**
  - History of severe asthma exacerbations requiring emergency care (most recent date) \_\_\_\_\_
  - Prior intubation for asthma
  - Hospital admission for asthma (most recent hospitalization date) \_\_\_\_\_
  - Prior office visits for asthma exacerbation (most recent 3 visit dates) \_\_\_\_\_
  - Prior use of IM or oral corticosteroids for asthma (most recent date prescribed) \_\_\_\_\_
  - Currently requires more than 2 canisters of short-acting beta agonist per month

**ALLERGIES**

1. **Current Diagnosis**
  - Allergic Rhinitis (Circle one): Seasonal Perennial
  - Allergic Conjunctivitis
  - Other (diagnosis) \_\_\_\_\_
2. **Current Allergy Medications (include medication name and frequency of daily use)**
  - Antihistamines \_\_\_\_\_
  - Steroid Nasal Inhaler \_\_\_\_\_
  - Other \_\_\_\_\_
3. **Please check any of the following which are true for your patient**
  - Allergies documented by skin testing or other diagnostic testing
  - Prior or current immunotherapy (allergy shots)

**MEDICAL PROVIDER COMMENTS:** Use reverse side if necessary.

Medical Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Please Print

Medical Provider Signature: \_\_\_\_\_

Return to: **Student Services Offices**  
Wagner House  
Lebanon Valley College  
101 North College Avenue  
Annville, PA 17003-1400